Please forward claims to:

Medical Eye Services

PO Box 25209
Santa Ana, CA 92799
(714) 619-4660 • Fax (714) 619-4662
(800) 877-6372 • www.mesvision.com

Great-West
LIFE & ANNUITY INSURANCE COMPANY

The Participating Provider Must Call MES to obtain an Eligibility Verification Number

CLAIM SUBMITTED FOR: EXAM ONLY ☐ MATERIALS ONLY ☐ EXAM & MATERIALS ☐

PART 1. TO BE COMPLETED AND SIGNED BY THE INSURED
USE BLACK INK ONLY!

PATIENT'S NAME (Last Name, First)	SEX (PLEASE CHECK BOX) MALE ☐ FEMALE ☐	EMPLOYEE'S SOCIAL SECURITY NO.
EMPLOYEE'S NAME	RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD	PATIENT'S BIRTHDATE MONTH DAY YEAR
STREET ADDRESS	NAME OF EMPLOYER **City of Long Beach**	GROUP POLICY NUMBER **50703**
CITY, STATE, and ZIP CODE		
OTHER VISION COVERAGE? IF "YES", "GIVE NAME OF CARRIER AND POLICY NUMBER YES ☐ NO ☐	WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? YES ☐ NO ☐	IF "YES," PLEASE EXPLAIN:
IF DEPENDENT AGE OVER CONTRACT AGE LIMIT, ARE THEY A FULL-TIME STUDENT? YES ☐ NO ☐	STUDENT'S SOCIAL SEC. NO.	NAME OF SCHOOL:

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim. I hereby assign payable benefits to participating providers.

SIGNATURE _____ DATE ___/___/___

PART 2 . TO BE COMPLETED BY DOCTOR
USE BLACK INK ONLY!

DATE OF EXAMINATION	REFRACTION		
	NO REFRACTION		
IF YOU PRESCRIBED GLASSES, **CHECK ALL THAT APPLY** SNGL VISION ☐ BIFOCAL VISION ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACT ☐			
HAS CATARACT SURGERY BEEN PERFORMED YES ☐ NO ☐ DATE:			
CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? YES ☐ NO ☐			
IS THIS A PRESCRIPTION CHANGE FROM LAST YEAR? YES ☐ NO ☐	BEST CORRECTED VISUAL ACUITY R.E. 20/ L.E. 20/		
RVS/CPT	EXAMINATION FEE $	RVS/CPT	OTHER CHARGES $

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.	.	.			
L.E.	.	.			

READING ADD R.E. + . L.E. + .

SPECIAL INSTRUCTIONS

Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4664

SIGNATURE DATE ___/___/___

PLEASE TYPE OR PRINT NAME OF DOCTOR | PARTICIPATING PROVIDER NO.

STREET ADDRESS

CITY, STATE and ZIP CODE

PART 3. TO BE COMPLETED BY DISPENSER
USE BLACK INK ONLY!

DATE OF ORDER	DEL. DATE	SNGL VISION ☐ BIFOCAL VISION ☐ TRIFOCAL ☐ PROGRESSIVE ☐ CONTACTS ☐
RIGHT LENS CHARGE		$
LEFT LENS CHARGE		$
OVERSIZE CHARGE, IF ANY		$
☐ PRISM CHARGE ☐ OTHER _____ ☐ SLAB OFF CHARGE _____		$
TINT CHARGE COLOR _____ No. _____		$
FRAME CHARGE NAME OF FRAME _____		$
IS FRAME SIZE LESS THAN		61 MM ☐ 56 MM ☐
CONTACT LENS CHARGE ☐ HARD ☐ SOFT		$
TOTAL FOR OPTICAL MATERIALS		$

COMMENTS

Participating Providers Must Call MES for Eligibility Verification at 800/877-6372 or 714/619-4664

SIGNATURE DATE ___/___/___

PLEASE TYPE OR PRINT NAME OF DOCTOR | PARTICIPATING PROVIDER NO.

STREET ADDRESS

CITY, STATE and ZIP CODE

EXAMINATION ELIGIBILITY VERIFICATION NO. _____

MATERIALS ELIGIBILITY VERIFICATION NO. _____

For your protection, State law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

M4438 (Rev. 3-03)